Servicemembers' and Veterans' Group Life Insurance

Accelerated Benefits Option

Administered by the
Office of Servicemembers' Group Life Insurance
213 Washington St.
Newark, NJ 07102-2999
Toll-Free: 1-800-419-1473
Fax: (973) 802-7991

SGLV-8284 revised August 1999

Instructions For Submitting a Claim for Accelerated Benefits

About The Accelerated Benefit

The accelerated benefit allows you to receive up to 50% of your Servicemembers' or Veterans' Group Life Insurance if you have been diagnosed by your physician as being terminally ill (as defined in Public Law 105-368) with nine (9) months or less to live. Only *you* (the insured) can apply for this benefit.

The amount of insurance proceeds payable to your beneficiary(ies) at the time of your death will be reduced by the amount of accelerated benefit you choose to receive now. Your premium will be lowered to reflect the reduced amount of your coverage.

How To Claim This Benefit

To submit a claim for accelerated benefits, you, your physician and, if you're covered under SGLI, your branch of service must complete the attached forms as indicated at the top of each form. Once all forms are completed, you should send the forms to:

OSGLI ABO Claim Processing
213 Washington St.
Newark, NJ 07102-2999

What You Should Know About Your Claim

You should be aware of the following before submitting your claim:

- Once we process your claim for accelerated benefits, we will send you a check for the amount you request* and an explanation of the amount.
- Once you cash the payment, the accelerated benefit cannot be revoked.
- You can receive this benefit only once during your lifetime.
- You may use this benefit for any purpose you choose. Its use is not limited to medical expenses.
- If you're covered under SGLI, OSGLI will notify your branch of service to reduce the face amount of your coverage and your premium rate.
- If you die before cashing the accelerated benefit check, someone should return the check to OSGLI.
- If your claim is not approved, we will notify you. You will then have the chance to submit additional medical information. You can also reapply at a later date if you believe your condition will qualify you for this benefit.

* The amount you request will be reduced by the amount of interest that would have been earned on it (over nine months) had you not claimed it. Therefore, the check you receive will be less than the amount you claim.

If you have any questions, please call us toll-free at 1-800-419-1473.
A customer service representative will assist you.

To Be Completed By Insured

a) Claim For Accelerated Benefits

Your Name	***Social Security Number***	
Your home address	***Date of birth***	***Branch of Service*** (if covered under SGLI)
Your mailing address (if different from above)	***Amount of SGLI Coverage*** **$**	***Amount of Claim*** (can be no more than one-half of coverage) **$**

Type of coverage:
(check one)

☐ SGLI *(select one of the following)*

○Active Duty ○Ready Reserve ○Army or Air National Guard ◉Separated or Discharged

☐ VGLI

Note: *If you checked SGLI, you must also have your military unit complete the attached form.*

I acknowledge that I have read all of the attached information about the accelerated benefit. I understand that I can get this benefit only once during my lifetime and that I can use it for any purpose I choose. I further understand that the face amount of my coverage will reduce by the amount of accelerated benefit I choose to receive now.

Your Signature _____ ***Date*** _____

b) Authorization to Release Medical Records

To all physicians, hospitals, medical service providers, pharmacists, employers, other insurance companies, and all other agencies and organizations:

You are authorized to release a copy of all my medical records, including examinations, treatments, history, and prescriptions, to the Office of Servicemembers' Group Life Insurance (OSGLI) or its representatives.

Printed Name _____

Signature _____ Date _____

A photocopy of this authorization will be considered as effective and valid as the original.
Valid for one year from date signed.

To Be Completed By Physician

Attending Physician's Certification

<table>
<tr><td>Patient's Name</td><td colspan="3">Patient's Social Security Number</td></tr>
<tr><td>Diagnosis</td><td colspan="3">ICD-9-CM Disease Code*</td></tr>
<tr><td colspan="4">Description of Present Medical Condition (please attach results of x-rays, E.K.G. or other tests)</td></tr>
<tr><td colspan="4">Is the patient capable of handling his/her own affairs? YES ☐ NO ☐</td></tr>
<tr><td colspan="4">The patient applied for an accelerated benefit under his/her government life insurance coverage. To qualify, the patient must have a life expectancy of nine (9) months or less. Does your patient meet this requirement?
YES ☐ NO ☐</td></tr>
<tr><td>Attending Physician's Name
(please print)</td><td>State in which you are licensed to practice</td><td colspan="2">Specialty</td></tr>
<tr><td rowspan="2">Mailing address</td><td colspan="3">Telephone Number</td></tr>
<tr><td colspan="3">Fax Number</td></tr>
<tr><td colspan="4">Signature _____ Date _____</td></tr>
</table>

*ICD-9-CM is an acronym for *International Classification of Diseases, 9th revision, Clinical Modification*

To Be Completed By Personnel Office of Servicemember's Unit

*(Complete this form **only** if the applicant for Accelerated Benefits is covered under SGLI.)*

Branch of Service Statement

Servicemember's Name	***Social Security Number***	***Branch of Service***
Amount of SGLI Coverage ***$***	***Monthly Premium Amount*** ***$***	
Name of Person Completing This Form	***Telephone Number***	***Fax Number***
Title of Person Completing This Form	***Duty Station and Address***	
Signature of person completing this form _____	***Date*** _____	

Notice: It is fraudulent to complete these forms with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts.